Gay Men's Health Crisis

2008 FEDERAL POLICY AGENDA

GMHC

Executive summary

Gay Men's Health Crisis, the world's oldest HIV/AIDS organization, promotes the following federal policy agenda for 2008.

Top priorities:

- The creation and implementation of a **National AIDS Strategy** for the first time in the 27 years of the AIDS epidemic
- **Comprehensive sex education and an end to federal funding of abstinence-only-until-marriage**
- **A one-year moratorium on Bush-Cheney Administration cuts to Medicaid** that would devastate people living with HIV/AIDS
- **The removal of language preventing the use of federal funds for syringe exchange,** which, along with condoms, is the most effective known HIV prevention technology
- The **lifting of the entry bar for HIV+ people** seeking to travel or immigrate to the U.S.

Other priorities:

- **Amendments to the Stop AIDS in Prison Act** to ensure that HIV testing in prison is voluntary and confidential
- **An end to the federal ban on gay and bisexual men donating blood**
- **Opposing the 24-month limit on emergency housing assistance** through the Ryan White CARE Act announced by the federal government in February 2008
- **Increased funding for HIV prevention and care, substance abuse treatment and mental health services**
- **Increased support for microbicides and vaccine research**
- **The promotion of HIV testing** as a routine aspect of medical care
- **Increased funding for Housing Opportunities for Persons with AIDS**
- **Expansion of Medicaid eligibility** for asymptomatic people living with HIV
- **Improvements to Medicare Part D and the AIDS Drug Assistance Program**
- **A transgender-inclusive Employment Non Discrimination Act** to outlaw workplace discrimination against gay, lesbian, bisexual and transgender people
- **A robust, generous reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR)** that promotes evidence-based prevention, treatment and care, not conservative ideology

Five top priorities

Gay Men's Health Crisis, the world's oldest HIV/AIDS organization, considers five issues of top priority for 2008:

- The creation and implementation of a National AIDS Strategy for the first time in the 27 years of the AIDS epidemic
- Comprehensive sex education and an end to federal funding of abstinence-only-until-marriage
- A one-year moratorium on Bush-Cheney Administration cuts to Medicaid that would devastate people living with HIV/AIDS
- The removal of language preventing the use of federal funds for syringe exchange, which, along with condoms, is the most effective known HIV prevention technology
- The lifting of the entry bar for HIV+ people seeking to travel or immigrate to the U.S.

National AIDS Strategy

GMHC calls for the development of a U.S. National AIDS Strategy. Numerous government and private studies have pointed to the need for better planning of U.S. HIV/AIDS policy and programming. For example, in 2004, the Institute of Medicine determined that federal financing of AIDS-related health care "does not allow for comprehensive and sustained access to quality HIV care" in the United States.[1]

HIV/AIDS remains one of the most significant public health problems in the United States. Over a million people—more than ever before—are now living with HIV/AIDS. HIV infection rates have not fallen in over a decade. In fact, infection rates may be 50% higher than we previously thought.[2] Half of those living with HIV/AIDS are not receiving lifesaving health care. African Americans represent nearly half of all new HIV infections; gay and bisexual men also represent half of new infections Nearly one in four newly infected individuals is a Black gay man. Unsatisfactory outcomes from the U.S. response to its domestic epidemic have serious economic costs: A 2003 study found that failure to meet the government's then goal of reducing HIV infections by half would lead to $18 billion in excess expenses through 2010.[3]

The U.S. HIV/AIDS epidemic requires a strategic plan of action.

The U.S. HIV/AIDS epidemic requires a strategic plan of action that promotes coordination across agencies, accountability, evidence-based policy, and a focus on improved prevention and treatment outcomes. The U.S. requires countries receiving assistance through the President's Emergency Plan for AIDS Relief (PEPFAR) to have a national AIDS strategy, yet since 1981 the U.S. has never had one itself.

GMHC calls for Congressional support to fund the development of a National AIDS Strategy that will transform the U.S. response to AIDS at home. We request a $1.4 million appropriation in fiscal year 2009 to the Office of National AIDS Policy (ONAP) in the White House. These funds will support six full-time staff, meeting expenses, regional consultations, and communications costs to develop and oversee the implementation of a National AIDS Strategy.

We also request guidance language in the appropriations report that calls on the new administration to develop and implement a National AIDS Strategy that engages multiple sectors in strategy development; is comprehensive across federal agencies; sets timelines and assigns responsibility for implementing changes; identifies targets for improved prevention and treatment outcomes and reduced racial disparities; and mandates annual reporting on progress.[4]

Sexuality education

GMHC calls for the defunding of abstinence-only-until-marriage programs.

Abstinence-only-until-marriage programs, currently receiving approximately $300 million a year in federal and state funds, are counterproductive and harmful to America's youth. They promote sexist gender stereotypes, anti-gay beliefs, and dangerous misinformation about contraception and sexually-transmitted diseases.

Abstinence-only-until-marriage programs have been unable to demonstrate effective behavioral outcomes. The U.S. Department of Health and Human Services commissioned an April 2007 study that found these programs to be ineffective in increasing teen rates of sexual abstinence. Following a comprehensive review of programs, the National Campaign to Prevent Teen and Unplanned Pregnancy reached the same conclusion.[5] Youth undergoing abstinence-only-until-marriage "education" have shown no significant differences in rates of pregnancy or sexually transmitted diseases.[6] Abstinence-only programs often involve the taking of "virginity pledges." Youth in communities where high numbers of students have taken "virginity pledges" are less likely than students in other communities to use contraception, have similar rates of sexually transmitted diseases (STDs) than those in other settings, and are less likely to seek medical attention in relation to a suspected sexually transmitted disease.[7]

Seventeen states have rejected federal abstinence-only dollars.

Abstinence-only programs promote regressive, sexist gender stereotypes; spread dangerous misinformation about the efficacy of contraception and how to prevent HIV infection; and demonstrate pervasive anti-gay bias and ignorance about people living with AIDS.

Seventeen states (Arizona, California, Connecticut, Colorado, Iowa, Maine, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Ohio, Rhode Island, Virginia, Wisconsin, and Wyoming) have taken a strong stance against the approach's biased and dangerous tactics, and are not accepting federal dollars for abstinence-only-until-marriage programs. They join thousands of health and medical professionals in concluding that abstinence-only-until-marriage is a public policy failure.

Rates of STDs, unwanted pregnancy, and HIV are up for people in New York and nationwide. The Centers for Disease Control and Prevention (CDC) recently reported that one in four teenage females has an STD; rates for Black females are one in two.[8] Last year teen pregnancy increased nationally for the first time since the early 1990s.[9] HIV among gay and bisexual men under 30 is up 33% in New York City since 2001.[10] Clearly we are failing to promote sexual health among young Americans.

Comprehensive programs about sexuality—medically accurate, age-appropriate education that includes information about both abstinence and contraception—have been found to be effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use among teenagers.[11] Comprehensive sex education has the support of leading public health institutions including the American Psychological Association, the American Medical

Association, the National Association of School Psychologists, the American Academy of Pediatrics, the American Public Health Association, the Society for Adolescent Medicine, and the American College Health Association.

GMHC calls for comprehensive sex education as the most effective protection for young people against disease and unwanted pregnancy.

Medicaid: A one-year moratorium on Bush-Cheney cuts that would devastate people living with HIV/AIDS

GMHC calls for a one-year moratorium on Bush-Cheney Administration cuts to Medicaid that would devastate people living with HIV and AIDS. H.R. 5613 would place a one-year moratorium on seven Administration-imposed Medicaid regulations that would make significant cuts to the program over the next five years.

We are deeply concerned about the impact that the regulations issued by the U.S. Department of Health and Human Services (HHS) would have on all Medicaid beneficiaries—including those with HIV/AIDS. Medicaid is the largest federal payer of HIV care and is estimated to provide access to care for more than 44% of people living with HIV/AIDS in the U.S. In New York State, an estimated 65% of all persons living with HIV rely on Medicaid for access to primary medical care.

The $20 to $49 billion in Medicaid cuts projected to occur over five years as a result of implementing these regulations is alarming. Reductions of this size in federal support for the Medicaid program, particularly in light of state-level cuts that are occurring due to the economic downturn, would jeopardize access to lifesaving care for people living with HIV/AIDS across the country. In New York State alone, these proposed changes would result in a reduction of at least $1.4 billion in federal Medicaid dollars in the first year, and get worse in later years.

Successful management of HIV disease requires coordination of a number of medical and non-medical interventions.

A number of the proposed policy changes would directly affect access to care for Medicaid beneficiaries with HIV/AIDS. Specifically, the restrictions on case management limit access to a critical benefit for people living with HIV/AIDS. Successful management of HIV disease requires coordination of a number of medical and non-medical interventions. GMHC's extensive experience with thousands of clients, as well as published studies, document that case management improves health outcomes and saves money by facilitating access to these services. Additionally, outpatient clinics in academic medical centers across the country provide medical homes to many people living with HIV/AIDS who would otherwise be unable to benefit from expert HIV care in their communities. The proposals to restrict services covered by hospital outpatient clinics and to eliminate graduate medical education payments will erode the resource base needed by these clinics to care for these patients, and will disproportionately affect minority populations that rely more heavily on outpatient clinics for access to care.

The proposed moratoria are critical to allowing adequate time to fully evaluate each regulation's impact on Medicaid beneficiaries. We feel strongly that this process must take place before changes of this magnitude are made to our country's health care safety net. **GMHC strongly supports efforts in Congress to limit the ability of a lame duck administration to further cut health care for people living with HIV/AIDS.**

Syringe exchange

GMHC calls for an end to the federal funds ban on syringe exchange. Syringe exchange programs (SEPs), which allow injection drug users to trade used needles for sterile ones and which safely dispose of used needles, are a proven means of reducing HIV transmission without increasing rates of drug use.[12] Their effectiveness has been borne out by study after study throughout the epidemic. There are currently an estimated 185 syringe exchange programs (SEPs) operating in 36 states, the District of Columbia, and Puerto Rico.[13]

Many SEPs, in addition to reducing the spread of HIV, offer services that further protect and educate injection drug users. Nearly all SEPs provide alcohol pads, male condoms, and referrals to substance-abuse treatment. Some SEPs also offer onsite medical care, counseling and testing for HIV and hepatitis C, and certain vaccinations.[14]

Injection drug users using SEPs have been shown in studies to be less likely to utilize local emergency rooms.[15] They are more likely to enter into detoxification programs and cease the dangerous practice of syringe-sharing.[16] HIV infection rates in communities with SEPs in place have shown overwhelming declines (for example, a 78% decline in reported HIV infections among intravenous drug users in New York City from 1990 to 2002).[17]

Since 1988, however, there has been a federal ban in place on funding these programs.

GMHC calls for legislative and administrative action that would end the federal ban and encourage the implementation of SEPs domestically and worldwide. We strongly advocate the following: striking language in appropriations bills that ban the use of federal funds for syringe exchange; directing the Centers for Disease Control and Prevention to allow the use of HIV prevention funds for syringe exchange domestically; and instructing the Office of the Global AIDS Coordinator to allow the use of HIV prevention funds for syringe exchange internationally.

In New York City, HIV infections among injection drug users dropped 78% since syringe exchange was introduced.

Immigration and travel ban

GMHC calls for the removal of discriminatory policies that ban HIV-positive non-citizens from entering the United States. For the last 21 years, U.S. policy has banned HIV-positive non-citizens from entering the United States and barred those already living here from attaining most types of legal status. These policies violate the human rights of immigrants and travelers as enumerated by recognized international treaties and conventions; perpetuate stigma and discrimination; and inhibit people living with HIV/AIDS from getting tested, diagnosed and accessing treatment and care. Highly skilled workers who have full health insurance through their employers cannot seek legal permanent residence in the United States if they have tested positive for HIV, unless they have a heterosexual spouse or child who is an American citizen or lawful permanent resident. While opposite-sex spouses can constitute such relatives, same-sex partners cannot. Thus, this policy discriminates in particular ways against gay and lesbian people. Further, the ban undermines the global fight against HIV/AIDS by blocking access to treatment and returning people to countries where HIV care is limited or wholly unavailable. This complicates the already challenging regimens of HIV treatment and the development of treatment-resistant strains of HIV.

The bar has resulted in AIDS-related fatalities abroad, as individuals cannot access life-saving medications or suffer violence based on HIV status and real or presumed sexual orientation. The ban also undermines public health within the United States, as

The ban undermines public health as immigrants are deterred from seeking HIV testing and treatment.

immigrants, prospective immigrants, and visitors either are actively deterred from seeking HIV testing and treatment, or avoid contact with providers out of fear of putting their immigration status in permanent limbo. This policy exacerbates the HIV/AIDS epidemic and leads to increased health care and economic costs over the long term.

The HIV bar was born of fear and intolerance, and it fails even by its own logic. GMHC views this policy as a violation of human rights and a threat to public health inside and outside the United States.

The HIV Nondiscrimination in Travel and Immigration Act of 2007 (H.R. 3337/S. 2486) was introduced by Congresswoman Barbara Lee (D-CA) in August 2007 and by Senators John Kerry (D-MA) and Gordon Smith (R-OR) in December 2007. The bill would amend the Immigration and Nationality Act by striking a provision that renders individuals with HIV inadmissible to the United States as visitors or immigrants. If passed, this bill would leave the determination of whether or not HIV constitutes a "communicable disease of public health significance" in the hands of the Department of Health and Human Services, the agency that makes this decision for all other medical conditions. **GMHC calls for the passage of the HIV Nondiscrimination in Travel and Immigration Act of 2007.**

Other priorities

Prison health

GMHC calls for changes to the Stop AIDS in Prison Act of 2007. H.R. 1943, the Stop AIDS in Prison Act, was introduced by Rep. Maxine Waters (D-CA) in April 2007. This legislation attempts to establish a routine testing system for incarcerated persons in the Federal Bureau of Prisons. However, the testing is involuntary; the language is vague and does not specify which inmates are to be tested; and the legislation does not provide for the confidentiality of personal medical records.

The Centers for Disease Control recommends that "HIV testing must be voluntary and free from coercion."[18] The World Health Organization has concluded that mandatory testing policies divert funding and staff from other proven prevention efforts in prison settings and are an ineffective use of resources.[19] While the Stop AIDS in Prison Act allows inmates to "opt out" of HIV tests, the discipline and power dynamics that characterize correctional institutions discourage them from doing so; routine testing procedures effectively operate as mandatory and involuntary.

GMHC strongly opposes any policy that would make HIV testing mandatory in any setting, either intentionally or in practice. Studies from Massachusetts and California have shown that informed voluntary (or "opt-in") testing not only is highly effective, but also is increasingly accepted by prisoners.[20] HIV tests in Federal prisons should be offered routinely through intake and regular medical care of inmates and should be completely voluntary.

GMHC strongly urges that "opt-in" or voluntary testing language be included in the Stop AIDS in Prison Act. The bill currently includes a provision by which a prisoner involved in an "exposure incident" may be tested without his or her consent (Section 3[10]). These "incidents" are vaguely defined in the legislation and likely leave that discretion to untrained corrections staff, increasing the likelihood of discrimination and stigma against those perceived to be HIV-positive. If this provision is to remain, GMHC urges that the legislation clearly define what constitutes an "exposure incident." It must also include fair and specific criteria for deciding to test an individual for HIV against his or her will.

More prisoners may opt in to HIV testing if proper confidentiality protections are assured.

The Stop AIDS in Prison Act of 2007 does not sufficiently ensure protections for prisoner confidentiality of HIV status, especially in regard to non-medical corrections staff. The Stop AIDS in Prison Act allows an opportunity to make changes in practice through the Bureau of Prisons that will protect those who are HIV-positive from violence and discrimination. The legislation must include provisions that protect the confidentiality of all personal health information, particularly HIV status.

GMHC strongly opposes any policy that would make HIV testing mandatory in any setting, either intentionally or in practice.

FDA Blood Ban

GMHC joins the American Red Cross and the nation's blood banks in calling for an end to the federal ban on gay and bisexual men donating blood. Much of today's medical care depends on a steady supply of blood from healthy donors. Despite shortages in the nation's blood banks, the Food and Drug Administration (FDA) continues to adhere to its ban on male donors who have sex with men. Under FDA guidelines, a man who has had sex with another man (MSM) since 1977 is ineligible to donate blood. Ever.

The bar on MSM blood donors is a holdover from a time when panic and discrimination drove health policy. In the more than two decades since the ban was enacted, scientific knowledge about blood screening and assuring the safety of transfusions has grown significantly. Thirteen tests (11 for infectious diseases) are performed on each unit of donated blood; these tests include screening for Human Immunodeficiency Virus (HIV).[21] In April 2008, Congressman Sam Farr from California called on the FDA to reassess its policy on this discriminatory ban, adding that, "The science doesn't seem to support that policy decision."[22] This comes after a petition by the American Association of Blood Banks, America's Blood Centers, and the American Red Cross to the FDA to repeal its prohibition on MSM as blood donors.

The American Red Cross and the nation's blood banks have petitioned the FDA to repeal the ban on gay male blood donors.

The cost of discrimination is high. Less than 5% of healthy Americans eligible to donate blood actually do so. In 2007, the blood supply was at a dangerous five-year low in New York. In California, officials in one school district have recently indicated that they may end blood drives in city schools if students are compelled to disclose information about their sexual activity. While this policy stigmatizes MSM and men who identify as gay, anyone who needs blood will pay the price. **GMHC calls for an end to the unjustifiable and discriminatory ban on gay male/MSM blood donors.**

Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, first passed in 1990, is the single largest federal program specifically designed to help people living with HIV and AIDS. After Medicaid and Medicare, it is the third largest source of federal funds to support the medical and care needs of half a million Americans living with HIV/AIDS. While Ryan White funds increased dramatically from 1991 to 2001, under the Bush-Cheney administration the program has remained essentially flat funded at about $2 billion annually.[23]

GMHC opposes the 24-month cap on emergency housing assistance announced by the Health Resources Services Administration in February 2008. In February 2008, the Health Resources Services Administration (HRSA), which administers the Ryan White Program, issued Policy Notice (99-02) in the Federal Register that would implement a 24-month cap on a client's utilization of the emergency housing assistance funds through the Ryan White CARE Act. GMHC strongly opposes this policy, which, despite significant community opposition, went into effect March 27, 2008.

The policy does not reflect a compassionate or adequate understanding of HIV infection, whereby health factors improve and decline over time. Accordingly, individuals may require assistance for a period of time, and later become healthy enough to be self-sufficient. In the event that a person's health declines again, policies that limit eligibility preclude individuals needing housing assistance from accessing such assistance. **GMHC calls for this Policy Notice to be withdrawn because it fails to provide the appropriate flexibility for management of HIV infection.**

Appropriations for HIV/AIDS prevention and care

GMHC, as a member of the AIDS Budget and Appropriations Coalition, calls for increased funding for HIV prevention and care. In a period of unprecedented deficit spending, money spent on prevention and getting people into care soon after they are infected pays for itself through savings in medical care. If people living with HIV are able to get into care sooner, and people who are HIV-negative stay HIV-negative, this country will save billions of dollars in medical costs that currently go to acute emergency medical treatment.

By expanding the core HIV/AIDS treatment and supportive services program, the Ryan White CARE Act, we as a nation can provide better care for people living with HIV/AIDS. Further, by setting priorities in the areas of housing assistance (the Housing Opportunities for People With AIDS Act) and prescription drug assistance (the AIDS Drug Assistance Program), and by reforming the Medicaid/Medicare system by expanding eligibility, we can help thousands of people slow their progression from HIV to AIDS.

Unfortunately, during the latest Ryan White re-authorization in 2006, Congress, in an attempt to redistribute Ryan White funding, cut funding to a number of Title I and Title II jurisdictions that continue to be at the center of the epidemic. New York was particularly hard hit, losing nearly $3 million in Minority AIDS Initiative funds and more than $10 million overall in Ryan White funds, even though New York's caseload continues to climb. This battle clearly demonstrates the need to expand the pie for treatment funding, rather than divide the pie into even smaller pieces.

GMHC also supports increased funding for CDC HIV prevention efforts. In March 2008 the CDC reported 52,878 new HIV infections in 45 states and the District of Columbia for 2006. In 2005, the CDC reported only 35,537 new infections in 38 states and the District of Columbia. Last fall the *Wall Street Journal* and *Washington Post* reported that the CDC will soon release data showing that the number of annual new HIV infections is as much as 50 percent higher than we thought it was. This increase may be due to better reporting methods, an increase in infections, or both. Either way, the news is not good. Data already show significant increases in HIV infections among gay and bisexual men, especially Black gay men. And rates of other STDs and teen pregnancy are also up for the first time since the early 1990s. Despite this increased need, funding for the CDC's prevention efforts has dropped 19% in real dollars since Bush-Cheney took office in 2001. Congress should increase funding for the CDC to make up for years of underfunding.

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Under the Bush-Cheney Administration, HIV has continued to spread unabated, with at least 40,000 new infections per year. In the United States it is estimated that one quarter of Americans who have HIV do not know it. Many are diagnosed too late to benefit from early medical care. Half of Americans living with HIV/AIDS do not receive regular HIV-related care, and half of those who are eligible for antiretroviral treatment do not receive this treatment.[24]

Black Americans are particularly hard hit by HIV. Although only 12% of the U.S. population, Blacks comprise 51% of new infections reported since 2001.[25] Gay men and other men who have sex with men (MSM) continue to be hard hit, comprising 72% of new infections among male adults and adolescents in 2005, even though only about 5 to 7% of male adults and adolescents identify as MSM.[26] Half a million MSM have been infected, and 300,000 have died from AIDS. Latinos and Native Americans are also disproportionately at risk for HIV, as are youth and women of color.[27] AIDS is the leading cause of death for Black women age 25–34, according to the Centers for Disease Control and Prevention (CDC).

Targeted prevention must be utilized in the communities most at risk for infection, particularly men who have sex with men, people of color, women, youth, substance users, and low-income Americans.[28] Each group is disproportionately impacted by HIV/AIDS and we as a society must step up our efforts to reach these vulnerable populations. We endorse the recommendations made by Dr. Robert Fullilove and the National Minority AIDS Council in 2006 to address the "root causes" of the HIV/AIDS epidemic among Black people, including addressing the lack of affordable housing, intolerable levels of poverty and unemployment, and the impact of incarceration.[29]

GMHC supports increased funding for substance abuse prevention and treatment, and mental health services. Crystal methamphetamine and other substances have been shown to be structural drivers of the HIV epidemic.[30] Crystal meth disproportionately affects many populations across the U.S., including truck drivers, Midwest "soccer moms," family farmers and others living in rural areas, and gay men living in big cities. GMHC supports increased funding for substance abuse prevention and treatment, and mental health services, at the Substance Abuse and Mental Health Services Administration (SAMHSA).

For specific budget requests, see Appendix A.

Microbicides

GMHC calls for support to strengthen and accelerate microbicide research and development. AIDS is now the number one cause of death in the United States among African American women aged 25–34. We will only see these rates decline when user-controlled HIV-prevention tools are researched, developed, and readily attainable. One of the most promising prevention tools is microbicides. Microbicides, both vaginal and rectal, are a new class of topical product—in the form of gel, cream, film, vaginal ring, or suppository—that could significantly reduce the risk of transmission of HIV and other sexually transmitted diseases.

Scientists estimate that a safe and effective microbicide could be available within five to seven years.

GMHC calls for the passage of the Microbicides Development Act (MDA; H.R. 1420 and S. 823). The MDA would authorize funding increases for the development of microbicides through the CDC, National Institutes of Health (NIH), and US Agency for International Development; require coordination between NIH and other federal agencies supporting microbicide development; and ensure a single line of administrative accountability and funding coordination through the establishment of a dedicated unit for microbicide research and development within the National Institute of Allergy and Infectious Diseases.

Scientists estimate that a safe and effective microbicide could be available within five to seven years and that the impact would be considerable. Mathematical models predict that even a partially effective microbicide could avert 2.5 million new HIV infections in women, men, and children worldwide over three years. Microbicides were hailed as one of the world's most promising new HIV-prevention technologies at the 2006 International AIDS Conference in Toronto.

Vaccines

GMHC calls for increased support for HIV/AIDS vaccine research. HIV/AIDS vaccine research is not being supported as it should by the private sector. Only 10% of funding for HIV/AIDS vaccine research and development comes from the large pharmaceutical and biotech companies that possess the unique expertise in innovation, product development, and manufacturing that is sorely needed.

GMHC calls for the passage of the Vaccines for the Future Act of 2007 (VFA; H.R. 1391.IH and S. 569.IS), which would provide incentives, such as pilot Advance Market Commitments, for the private sector to invest in the research and development of vaccines against the infectious diseases. These include HIV/AIDS as well as tuberculosis, pneumonia, malaria, and others. Such diseases kill 11 million people per year worldwide, most in resource-poor nations.

The VFA calls for a comprehensive strategy to speed the development, testing, and distribution of vaccines and other new prevention technologies. It supports increased direct funding, especially to public-private partnerships (such as the International AIDS Vaccine Initiative) that currently account for approximately 75% of the projects working to develop drugs to prevent and treat neglected diseases. The VFA promotes improved regulatory procedures and offers support for the clinical trials that are critical to the efforts to develop safe and effective means of combating public health crises in the United States and across the globe.[31]

Testing

GMHC calls for making voluntary HIV testing a routine aspect of medical diagnostic visits. HIV testing helps prevent the spread of HIV throughout the United States by reducing the number of Americans who spread the virus unknowingly. Approximately half of all new HIV infections are spread by people who are unaware of their HIV status, and who have been infected themselves for less than two years.[32]

GMHC has long believed that testing for HIV promotes both prevention and treatment. HIV-positive individuals who remain unaware of their status have high HIV viral loads and are more likely to infect others. Conversely, studies have shown that individuals who test positive exhibit behavior that curtails the spread of the virus; they either avoid high-risk activity or take safer precautions.[33] Individuals who test positive within two years of infection are set on a path to manage their HIV infection, receiving early treatment that can reduce HIV viral loads and may put them at lower risk for spreading the virus.

The Centers for Disease Control and Prevention (CDC) estimate that one in four HIV-positive Americans—or about 250,000 to 300,000 people—are infected with HIV but are undiagnosed and therefore unaware of their status. Many of these are in high-risk categories, such as men who have sex with men (MSM) and intravenous drug users, and these groups are less likely to seek out quality health care. Other communities, such as Black and Latina women and low-income Americans, are also at elevated risk.

GMHC calls for efforts to increase access to voluntary HIV testing and counseling and to remove any barriers to testing utilization. Such efforts include making HIV testing and counseling a routine component of medical care. Routine offering of HIV testing in diagnostic settings should include the dissemination of critical information, written and informed consent, and pre- and post-test counseling so patients can make voluntary, informed health decisions.

Housing Opportunities for People with AIDS (HOPWA)

GMHC calls for an increase in funding for the Housing Opportunities for Persons with AIDS (HOPWA) program.

GMHC recognizes the crucial role of stable housing to the ongoing health and risk behavior of people living with HIV and AIDS.[34] Housing is one of the greatest needs of people living with HIV across the United States. According to the National AIDS Housing Coalition (NAHC), approximately 50% of all people with HIV/AIDS in the United States require some form of housing assistance, meaning that as many as 600,000 people will be in need of housing assistance in 2009.[35]

The Housing Opportunities for Persons with AIDS (HOPWA) program has provided rental assistance, supportive housing, and short-term emergency housing assistance to people living with HIV/AIDS since 1992. HOPWA funds are also used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services. Benefits such as these have been shown to help individuals reduce high-risk behaviors and adhere to HIV treatment and thus are an effective means of stemming the spread of HIV/AIDS in the United States. However, while the FY 2008 appropriation for HOPWA was $300.1 million, the largest budget for the program since its inception, President Bush has recommended no increase to the program for FY 2009.

GMHC joins the National AIDS Housing Coalition in calling for HOPWA funding to be increased to $470 million for FY 2009. The additional $170 million would provide housing assistance to another 40,000 people with HIV/AIDS across the country. It would aid the development of new housing for people with HIV/AIDS, allow communities to reduce HOPWA waiting lists, and provide individuals receiving care through the Ryan White CARE Act the housing stability essential to the success of their medical treatment.

Medicaid/Medicare Reform—ETHA and ADAP

GMHC supports expansion of Medicaid eligibility for people with HIV who are not yet disabled by AIDS. Medicaid is the number one public payer of HIV and AIDS care and treatment in the United States, followed closely by Medicare. Nationwide, 55% of all people living with AIDS (including 90% of all children living with AIDS) access health care through Medicaid.

Implementing ETHA could reduce the death-rate for people living with HIV/AIDS by as much as 60%.

Without these two pillars of the social safety net, there would be no meaningful HIV care for poor and low-income people living with HIV and AIDS.

Current Medicaid policy is based on the irrational logic that in order to be eligible for Medicaid, people infected with HIV would have to become disabled by AIDS before they can receive access to treatment and care that could have prevented their disability in the first place. Early access to care and treatment can delay the progression from HIV to AIDS. Yet, many states withhold Medicaid benefits until applicants are disabled by AIDS. The Early Treatment for HIV Act (ETHA) (H.R. 3326/S. 860), currently pending in Congress, would allow states to extend Medicaid coverage to pre-disabled people living with HIV. Treatment advances have improved both the quality of and duration of life of many people living with HIV. Studies have shown that implementing ETHA could reduce the death-rate for people living with HIV/AIDS by as much as 60% and slow disease progression.[36] Not only would this measure bring access to thousands of non-disabled, low-income people living with HIV. It would also help decrease the rate of transmission and the burden of tertiary care (e.g. emergency room visits and costly AIDS

care) by putting more people on the path to early and effective treatment and management. **GMHC strongly endorses passage of the Early Treatment for HIV Act (ETHA), which would allow states to amend their Medicaid eligibility requirements to include uninsured, asymptomatic low-income people living with HIV.**

GMHC supports critical changes to Medicare Part D and ADAP policies. Many people living with HIV/AIDS are dually eligible for Medicare and Medicaid. Medicare Part D, launched two years ago, imposed increased cost-sharing, decreased formularies, and a massive new bureaucracy on an already vulnerable population whose lives depend on uninterrupted access to prescription drugs. AIDS Drug Assistance Programs (ADAPs) have stepped in to help Part D recipients in some states cover co-payments, deductibles, and other cost-sharing. Currently, this ADAP supplement cannot be counted toward an individual's "True Out Of Pocket" (TrOOP) costs which must be met before a recipient can climb out of the "doughnut hole" and again receive Part D coverage. Consequently, ADAPs may be covering beneficiaries' entire prescription drug costs for the remainder of a given calendar year, and the beneficiaries are limited to more restrictive ADAP formularies. In other words, ADAPs—already under-funded—are, in effect, underwriting Part D plans. This is untenable. It is only fair to allow ADAP contributions to count towards TrOOP. If ADAP did count toward TrOOP, Medicare catastrophic coverage would kick in and ADAP dollars would be freed up to help other needy individuals. Additionally, Medicare beneficiaries with HIV/AIDS would have better access to the host of medications they need to treat co-occurring conditions and side-effects from their HIV treatment.
GMHC strongly recommends that these ADAP payments count toward the TrOOP limit.

The Employment Non Discrimination Act: Guaranteeing civil rights for all workers

GMHC calls for the passage of an Employment Non Discrimination Act which would outlaw workplace discrimination against lesbian, gay, bisexual and transgender people. Currently, federal law provides basic legal protection against employment discrimination on the basis of race, gender, religion, national origin, and/or disability. Absent from this list of protected categories are sexual orientation and gender identity/expression. It is legal to fire someone based on their sexual orientation in 30 states. It is legal to fire someone based on their gender identity or expression in 37 states. The Employment Non-Discrimination Act (ENDA), as originally introduced in 2007, would make it unlawful to refuse employment to, or fire, an individual based on that individual's real or perceived sexual orientation or gender identity or expression.

GMHC supports a bill that covers both sexual orientation and gender identity.

ENDA was passed in the House of Representatives in November 2007. However, the bill did not include protections for the whole lesbian, gay, bisexual and transgender (LGBT) community. Unfortunately, key supporters of ENDA in the House decided to strip gender identity from the bill. This move hurt not only those transgender people, but also gays, lesbians, bisexuals and others who do not conform to mainstream gender norms (such as "effeminate" men or "masculine" women).

Now ENDA has moved onto the Senate, where Senator Edward Kennedy is expected to introduce it this year. The White House has indicated that the President may veto the bill if it does pass the Senate.[37] Passage of ENDA is an essential step towards securing fundamental civil rights protections. However, GMHC supports a bill that covers both sexual orientation and gender identity. Because health insurance is tied to employment for many people in the US, enactment of this legislation is particularly urgent for LGBT workers with HIV and AIDS.

We also understand that antigay bias and homophobia are structural drivers of HIV. Half of new infections in the U.S. are gay and bisexual men. Transgender women are also at elevated risk for HIV. Passing a federal law banning anti-LGBT discrimination sends a message that LGBT Americans deserve equal treatment under the law and in society. Helping to eliminate anti-LGBT discrimination in the workplace reflects the mission and values of Gay Men's Health Crisis, and also addresses key structural drivers of the AIDS epidemic. We also feel strongly that no one should be left behind, including our transgender sisters and brothers. **GMHC calls for the passage of a trangender-inclusive ENDA to outlaw discrimination against lesbian, gay, bisexual and transgender people.**

The President's Emergency Plan for AIDS Relief

GMHC supports a robust reauthorization of the President's Emergency Plan for AIDS Resources (PEPFAR). PEPFAR is one of the great accomplishments of the Bush-Cheney Administration. Globally, PEPFAR has channeled over $19 billion in aid for HIV/AIDS prevention, treatment and care toward Africa and other parts of the world since 2003. Millions of infections have been prevented, and 1.4 million are in care thanks to PEPFAR. However, HIV prevention efforts are complicated by language requiring that one-third of prevention dollars be reserved for abstinence-only-until-marriage, and by the requirement that aid recipients pledge to oppose prostitution.

GMHC supports an amendment to PEPFAR that would end the U.S. policy that groups sign a pledge to oppose prostitution.

GMHC supports reauthorizing PEPFAR at a level of $10 billion a year over five years. This would support treatment for 3 million individuals, including nearly half a million orphans. It would also provide treatment to one third of people in clinical need in the world's poorest countries affected by AIDS. GMHC supports an amendment to PEPFAR that would end the U.S. policy that groups sign a pledge to oppose prostitution. It also supports the Senate version of PEPFAR's language lifting the entry ban for HIV+ individuals. This entry ban prevents many health workers from Africa and elsewhere from traveling to the U.S. for training, hindering efforts to fight the epidemic around the globe. GMHC also calls for the removal of language triggering a report if less than 50% of prevention funds are spent on "behavior change" related to abstinence-only-until-marriage.

GMHC supports the House version of PEPFAR's language that would allow family planning groups that are promoting contraception to receive PEPFAR funds and referrals for HIV testing and education. We also support the House version's language calling on the President to develop and submit to Congress a strategy for fighting gender inequality and the sexual exploitation of girls that drives the epidemic. **GMHC supports a generous PEPFAR that promotes evidence-based prevention, treatment and care, not conservative ideology.**

For specific global budget requests, see Appendix B.

References

[1] Institute of Medicine, *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White* (Washington, DC: 2004): 9.

[2] "Estimate of AIDS Cases In U.S. Rises: New Test Places the Rate Of Infection 50 Percent Higher." *The Washington Post*, December 1, 2007.

[3] Holtgrave, D, Pinkerton, S, "Economic Implications of Failure to Reduce Incidence HIV Infections by 50% by 2005 in the United States." JAIDS, 33:171–174.

[4] For more information, see Chris Collins, *Improving Outcomes: Blueprint for a National AIDS Plan* (Open Society Institute, New York: 2007). Available online at www.nationalaidsstrategy.org

[5] Impacts of Four Title V, Section 510 Abstinence Education Programs (Mathematica Policy Research, Inc. 2007), 59–61; Douglas Kirby, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 2001); Hauser D. *Five Years of Abstinence-Only-Until-Marriage Education: Assessing the Impact*. Washington, DC: Advocates for Youth, 2004.

[6] Impacts of Four Title V, Section 510 Abstinence Education Programs, op. cit.

[7] Peter Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges and the Transition to First Intercourse," *American Journal of Sociology* 106.4 (2001): 859–912.

[8] Press Announcement from 2008 National STD Prevention Conference, March 2008.

[9] Gardiner Harris, "Teenage Birth Rate Rises for First Time Since '91," *New York Times*, December 6, 2007.

[10] New York City Department of Health and Mental Hygiene. Press Statement, September 11, 2007.

[11] Douglas Kirby, *No Easy Answers* (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 1997); Douglas Kirby, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington, D.C.: National Campaign to Prevent Teen Pregnancy, 2001); and David Satcher, *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, June 2001.

[12] Des Jarlais DC, Perlis T, Arastech K, Torian L, Beatrice S, Milliken J, Mildvan D, Yancovitz S, Friedman S. 2005. "HIV Incidence Among Injection Drug Users in New York City, 1990 to 2002: Use of Serologic Test Algorithm to Assess Expansion of HIV Prevention Services." *American Journal of Public Health*. 95(8):1439–1444.

[13] McKnight CA, Des Jarlais DC, Perlis T, Krim M, Ruiz M, Purchase D, Solberg A, Mastro TD. "Syringe Exchange Programs – United States, 2005." *Morbidity and Mortality Weekly Report (MMWR)*. Atlanta, CDC, Nov. 9, 2007, 56(44): 1164–1166.

[14] Ibid.

[15] Pollack HA, Khoshnood K, Blankenship KM, Altice FL. 2002. "The Impact of Needle Exchange-based Health Services on Emergency Department Use." *Journal of General Internal Medicine* 17 (5), 341–348.

[16] Strathdee SA, Celentano DD, Shah N, Lyles C, Stambolis VA, Macalino G, Nelson K, Vlahov D. 1999. "Needle-exchange attendance and health care utilization promote entry into detoxification." *Journal of Urban Health*. 76(4):448-460; and Bluthenthal RN, Kral AH, Gee L, Erringer EA, Edlin BR. 2000. "The effect of syringe exchange use on high-risk injection drug users: a cohort study." *AIDS*. 14(5):605–11.

[17] Des Jarlais et al., op. cit.

[18] Centers for Disease Control and Prevention. (2006). *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. Retrieved March 12, 2008 from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

[19] American Civil Liberties Union. (September 24, 2007). "The ACLU Opposes H.R. 1943, The Stop AIDS in Prison Act of 2007."

[20] Liddicoat, Rebecca V.; Zheng, Hui; Internicola, Jeanne; Werner, Barbara G.; Kazianis, Arthur; Golan, Yoav; Rubinstein, Eric P.; Freedberg, Kenneth A.; Walensky, Rochelle P. (2006). "Implementing a Routine, Voluntary HIV Testing Program in a Massachusetts County Prison." *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. Vol. 83, No. 6.

[21] *Blood Centers of the Pacific, 56 Facts about Blood and Blood Donation*, http://www.bloodcenters.org/aboutblood/bloodfacts.htm, accessed April 8th, 2008.

[22] *CQ Today*, "Time for FDA to End 'Discriminatory' Blood Donation Policy, Farr Says," April 2, 2008.

[23] "The Ryan White Program," HIV/AIDS Policy Fact Sheet (Menlo Park, CA: Kaiser Family Foundation, March 2007). http://www.kff.org/hivaids/upload/7582_03.pdf. Accessed April 17, 2008.

[24] Chris Collins, *Improving outcomes: Blueprint for a national AIDS plan for the United States*, New York: Open Society Institute, 2007.

[25] Ibid.

[26] "HIV/AIDS among men who have sex with men," Atlanta: Centers for Disease Control and Prevention, May 2007, http://www.cdc.gov/hiv/topics/msm/resources/factsheets/print/msm.htm. Accessed June 18, 2007.

[27] CDC HIV/AIDS Fact Sheets. HIV/AIDS among Hispanics/Latinos; HIV/AIDS among American Indians and Alaska Natives; HIV/AIDS among youth; HIV/AIDS among women. Atlanta: CDC, June 2006–August 2007. All at www.cdc.gov. Accessed November 20, 2007.

[28] Four in ten new infections in Massachusetts are connected to dirty needle use; among women, six in 10 new infections are linked to intravenous drug use. Reilly, 2005.

[29] Fullilove, R., *African Americans, health disparities, and HIV/AIDS* (Washington, DC: National Minority AIDS Council, November 2006).

[30] Celentano, D. D., Valleroy, L. A., & Sifakis, F. (2006). Associations Between Substance Use and Sexual Risk Among Very Young Men Who Have Sex With Men. *Sexually Transmitted Diseases*, Volume 33(4), 265–271. Diaz, R. M., Heckert, A. L., & Sánchez, J. (2005) Reasons for stimulant use among Latino Gay men in San Francisco: A comparison between methamphetamine and cocaine users. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Volume 82, Supplement 1, pp. i71–i78(1).

[31] IAVI, "'Vaccine for the Future Act' Calls for Financial Support for Advance Market Commitments." Press release, February 15, 2007. Available at http://www.iavi.org/viewfile.cfm?fid=44362.

[32] Cates, W.,Chesney, MA., Cohen, MS. (1997). "Primary HIV Infection—A Public Health Opportunity." *American Journal of Public Health*, 87:12.

[33] Marks G, Crepaz N, and Janssen RS, "Estimating Sexual Transmission of HIV from Persons Aware and Unaware that they are infected with the Virus in the USA," *Concise Communication*, 2006. 20:1447–1450

[34] Aidala, A. et al. (2005). "Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy." *AIDS and Behavior*, Vol. 9, No. 3.

[35] National AIDS Housing Coalition. *HOPWA 2009 Need: NAHC Recommends $470 million*. Retrieved from http://nationalaidshousing.org/PDF/FY09HOPWANeedPaper.pdf

[36] Greenwald, R., Early Treatment for HIV Act (ETHA) Fact Sheet, http://www.taepusa.org/documents/ETHA%20One%20Page%20Fact%20Sheet%202004.pdf, accessed April 8th, 2008

[37] American Civil Rights Union (ACLU), Update: Bittersweet Victory for ENDA, http://www.aclu.org/lgbt/discrim/29544res20070424.html, November, 2007, accessed April 8th, 2008

About Gay Men's Health Crisis

Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. GMHC serves one in every six persons diagnosed with AIDS in New York City. As the world's oldest AIDS service provider, GMHC helps over 15,000 men, women and children and their families each year. GMHC offers a wide range of comprehensive client services, including hot meals, benefits/entitlements advocacy, health care advocacy, case management, legal assistance, HIV counseling and testing, individual and group counseling services, prevention education, home-based support, and mental health services.

GMHC has been on the frontlines of the AIDS epidemic since it began, focused on the communities most threatened by HIV and expanding our service provision as the epidemic shifts and grows. The number of GMHC clients has increased by over 50% just since 2000. Our clients reflect the diversity of the HIV epidemic:

- 69% are people of color;
- 64% are gay, lesbian, bisexual;
- 23% are women; and
- over 50% reside outside of Manhattan.

Additionally, nearly one-third of our clients are 50 years of age or older, while 28% of all new prevention clients are under 30. Of our total clients served we continue to see a larger proportion living in poverty – approximately 72% are living on an annual income of less than $10,000. Over 70% of GMHC clients rely on Medicaid, while 15% rely on the AIDS Drug Assistance Program (ADAP) for their medical care and life-saving prescription drugs.

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Appendix A: AIDS Budget and Appropriations Coalition

FY 2009 Appropriaions for Federal HIV/AIDS Programs

April 14, 2008

(Increases or decreases from previous fiscal year are shown in parentheses; fiscal year 2009 requests reflect increase over FY 2009)

	Program	FY 2007 Final	FY 2008 Final	FY 2009 President's Budget	FY 2009 Coalition Request
HRSA	**HRSA: Ryan White CARE Act Total**	$2.138 b (+ $75.8 m)	$2.1668 b (+ $29 m)	$2.1679 b (+ $1.1 m)	$2.7816 b (+ $614.49 m)
HRSA	**Title I (Part A)**	$604 m (+ $0 m)	$627.15 m (+ $23.16 m)	$619.42 m (– $7.7 m)	$840.4 m (+ $213.25 m)
HRSA	**Title II: Care (Part B)**	$405.9 m (+ $75.8 m)	$400.9 m (– $5 m)	$394.94 m (– $6.0 m)	$496.2 m (+ $95.3 m)
HRSA	**Title II: ADAP (Part B)**	$789.6 m (+ $0 m)	$794.4 m (+ $4.8 m)	$814.5 m (+ $20.1 m)	$929 m (+ $134.6 m)
HRSA	**Title III (Part C)**	$193.7 m (+ $0 m)	$198.75 m (+ $5 m)	$198.75 m (+ $0 m)	$299.3 m (+ $100.5 m)
HRSA	**Title IV (Part D)**	$71.8 m (+ $0 m)	$73.7 m (+ $1.9 m)	$73.7 m (+ $0 m)	$122.5 m (+ $48.8)
HRSA	**Part F: AETCs**	$34.7 m (+ $0 m)	$34.1 m (– $0.6 m)	$28.7 m (– $5.4 m)	$50.0 m (+ $15.9 m)
HRSA	**Part F: Dental**	$13.1 m (+ $0 m)	$12.86 m (– $0.23 m)	$12.86 m (+ $0 m)	$19 m (+ $6.14 m)
HRSA	**SPNS**	$25.0 m	$25.0 m	$25.0 m	$25.0 m
HRSA	**HRSA: Community Health Centers**	$1.998 b (+ $206.9 m)	$2.065 b (+ $77 m)	$2.092 m (+ $27 m)	$2.313 m (+ $248 m)
HRSA	**HRSA: Title X**	$283 m (– $0.04 m)	$300 m (+ $17 m)	$300 m (+ $0 m)	$400 m (+ $100 m)
CDC	**Total–HIV, Hep, STD, TB, line**	$1.0025 b (+ $39.1 m)	$1.002 b (– $0.5 m)	$1 b (– $2 m)	$1.8349 b (+ $832.6 m)
CDC	**HIV Prevention & Surveillance**	$695.5 m (+ $43.8 m)	$692 m (– $3.5 m)	$691 m (– $1 m)	$1.3 b (+ $608 m)
CDC	**Viral Hepatitis**	$17.4 m (– $0.2 m)	$17.6 m (+ $0.2 m)	$17.5 m (– $0.08 m)	$67.6 m (+ $50 m)
CDC	**STD Prevention**	$155 m (– $2.2 m)	$152 m (– $3 m)	$152 m (+ $0 m)	$167.3 m (+ $15 m)
CDC	**TB Prevention**	$135 m (– $2.1 m)	$140 m (+ $5 m)	$140 m (+ $0 m)	$300 m (+ $159.6 m)
CDC	**DASH–HIV Prevention Education**	$40.9 m (+ $0 m)	$40.2 m (– $0.7 m)	$40.1 m (– $0.1 m)	$66.64 m (+ $26.4 m)
	Minority HIV/ AIDS Initiative (across multiple programs)	$400 m (+ $1.1 m)	$402.6 m (+ $2.6 m)	$387 m (– 15.6 m)	$610 m (+ $223 m)
	HUD: HOPWA	$286.1 m (+ $0 m)	$300.1 m (+ $14 m)	$300.1 m (+ $0 m)	$470 m (+ $169.9 m)
	NIH [Transfer to Global AIDS]	$28.9 b (+ $619.5 m) [– $99 m]	$29.2 b (+ $330 m) [– $295 m]	$29.2 b (+ $0 m) [– $300 m]	$33.58 b (+ $4.38 b) [– $300 m]
	AIDS Research	$2.9 b (+ $0 m)	$2.9 b (– $0 m)	$2.9 b (– $0 m)	$3.35 b (+ $430 m)
	ACF: Abandoned Infants Assistance	$11.84 m (+ 0)	$11.63 m (– $0.2 m)	$11.63 m (+ $0 m)	$20 m (+ $8.37 m)
	ACF: Community-Based Abstinence Education	$113 m (+ $0 m)	$113 m (+ $0 m)	$141 m (+ $28 m)	$0 m (– $113 m)
	SAMHSA: Center for Substance Abuse Treatment	$399 m (+ $0 m)	$400 m (– $1 m)	$337 m (– $63 m)	$420 m (+ $20 m)
	Substance Abuse Block Grant	$1.759 b (+ $0 m)	$1.759 b (– $0 m)	$1.779 b (+ $20 m)	$1.8587 m (+ $100 m)
	SAMHSA: Center for Substance Abuse Prevention	$193 m (+ $0 m)	$194 m (+ $1 m)	$158 m (– $36 m)	$215 m (+ $21 m)
	SAMHSA: Center for Mental Health Services (CMHS)	$884 m (– $0.2 m)	$911 m (– $27 m)	$784 m (– $126 m)	$1.0448 b (+ $133.9 m)
	Subset of CMHS: Mental Health Block Grant	[$428 m] (– $0.18 m)	[$421 m] (– $7 m)	[$418 m] [(+ $0 m)]	[$482.9 m] [(+ $61.9 m)]

Appendix B: Global HIV/AIDS Programs

Program	FY 2007 Final	FY 2008 Final	FY 2009 President's Budget Request	FY 2009 Coalition Request
Foreign Operations Portfolio				
HIV/AIDS in USAID Child Survival and Health Programs Fund	$346 m (– $0.5 m)	$350 m (– $4 m)	$342 m (– $8 m)	$1 b (+ $650 m)
Global HIV/AIDS Initiative	$2.870 b (+ $1.093 b)	$4.7 b ($4.15 b for 15 focus countries) (+ $1.28 b)	$4.8 b ($4.1 b for 15 focus countries) (– $50 m)	$8.4 b (+ $3.7 b)
Global Fund	$624 m (+ $174 m)	$550 m (– $74 m)	$200 m (– $350 m)	$2 b (+ $1.45 b)
TB	$79 m (– $141 m)	$153 m (+ $74 m)	$84.5 m (– $68.5 m)	$550 m (+ $397 m)
Malaria	$248 m (– $148 m)	$350 m (includes $270 m) for PMI) (+ $102 m)	$385 m (all for PMI) (+ $35 m)	$450 m (+ $100 m)
Labor/HHS Portfolio and Total				
Global Fund	$99 m (– $0 m)	$300 m (+ $201 m)	$300 m (+ $0 m)	$0 m (– $300 m)
CDC Global AIDS Program	$123 m (+ $1 m)	$121 m (– $2 m)	$119 m (– $2 m)	$119 m (– $2 m)
Total	$4.38 b (+ $1.32 m)	$5.86 b (+ $1.48 m)	$5.53 b (– $443.5 m)	$12.52 b (+ $6 b)

Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. Our Mission is to reduce the spread of HIV disease, help people with HIV maintain and improve their health and independence, and keep the prevention, treatment and cure of HIV an urgent national and local priority. In fulfilling this Mission, we will remain true to our heritage by fighting homophobia and affirming the individual dignity of all gay men and lesbians.

For more information, please call the Hotline or visit our Web site.

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